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BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **EVA BEDFORD-OPPONG** **P.O. Box 741309** **Los Angeles, CA 90004** **Registered Nurse License No. 638447** **Nurse Practitioner Advanced Certification No. 19215** Respondent.	Case No. 2010-241 **ACCUSATION**

Complainant alleges:

PARTIES

1. Louise R. Bailey, M.Ed., RN (Complainant) brings this Accusation solely in her official capacity as the Interim Executive Officer of the Board of Registered Nursing (Board), Department of Consumer Affairs.

2. On or about June 11, 2004, the Board issued Registered Nurse License Number 638447 to Eva Bedford-Oppong (Respondent). The Registered Nurse License was in full force and effect at all times relevant to the charges brought herein and will expire on November 30, 2011, unless renewed.

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3. On or about August 6, 2009, the Board issued Nurse Practitioner Advanced Certification Number 19215 to Respondent. The Nurse Practitioner Advanced Certification was in full force and effect at all times relevant to the charges brought herein and will expire on November 30, 2011, unless renewed.

JURISDICTION

4. This Accusation is brought before the Board under the authority of the following laws. All section references are to the Business and Professions Code (Code) unless otherwise indicated.

STATUTORY PROVISIONS

5. Code section 2750 provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

6. Code section 2764 provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license. Under section 2811(b) of the Code, the Board may renew an expired license at any time within eight years after the expiration.

7. Code section 2761 states:

"The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:

"(a) Unprofessional conduct, which includes, but is not limited to, the following:

"(1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions."

8. California Code of Regulations, title 16, section 1442, states:

"As used in Section 2761 of the code, 'gross negligence' includes an extreme departure from the standard of care which, under similar circumstances, would have ordinarily been exercised by a competent registered nurse. Such an extreme departure means the repeated failure to provide nursing care as required or failure to provide care or to exercise ordinary precaution in a single

situation which the nurse knew, or should have known, could have jeopardized the client's health or life."

9. California Code of Regulations, title 16, section 1443, states:

"As used in Section 2761 of the code, 'incompetence' means the lack of possession of or the failure to exercise that degree of learning, skill, care and experience ordinarily possessed and exercised by a competent registered nurse as described in Section 1443.5."

10. California Code of Regulations, title 16, section 1443.5 states:

"A registered nurse shall be considered to be competent when he/she consistently demonstrates the ability to transfer scientific knowledge from social, biological and physical sciences in applying the nursing process, as follows:

"(1) Formulates a nursing diagnosis through observation of the client's physical condition and behavior, and through interpretation of information obtained from the client and others, including the health team.

"(2) Formulates a care plan, in collaboration with the client, which ensures that direct and indirect nursing care services provide for the client's safety, comfort, hygiene, and protection, and for disease prevention and restorative measures.

"(3) Performs skills essential to the kind of nursing action to be taken, explains the health treatment to the client and family and teaches the client and family how to care for the client's health needs.

"(4) Delegates tasks to subordinates based on the legal scopes of practice of the subordinates and on the preparation and capability needed in the tasks to be delegated, and effectively supervises nursing care being given by subordinates.

"(5) Evaluates the effectiveness of the care plan through observation of the client's physical condition and behavior, signs and symptoms of illness, and reactions to treatment and through communication with the client and health team members, and modifies the plan as needed.

"(6) Acts as the client's advocate, as circumstances require, by initiating action to improve health care or to change decisions or activities which are against the interests or wishes of the

client, and by giving the client the opportunity to make informed decisions about health care before it is provided."

COST RECOVERY PROVISION

11. Code section 125.3 provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

DRUG DEFINITION

12. Heparin Flush IV is an anticoagulant used to keep intravenous (IV) catheters open and flowing freely. Heparin helps to keep blood flowing smoothly and from clotting in the catheter by making an anti-clotting protein in the body work better.

SUMMARY OF FACTS

13. Since about June 2006, Respondent was employed as a registered nurse in the Neonatal Intensive Care Unit at Cedars-Sinai Medical Center (CSMC), Los Angeles. On or about November 18, 2007, while working the night shift (7 p.m. to 7 a.m.), Respondent was assigned to cross-train[1] with Nurse Sandhya Shetty (Nurse Shetty) in the Pediatrics Unit (4NE). Their patients included twins, Patient #1 and Patient #2, who were housed in the same room. Patient #1 was a 9-day old female infant admitted to 4NE on November 17, 2007 with a rash. Physician's order was for Acyclovir every 8 hours IV, and Vancomycin every 8 hours IV. Patient #2 was a 9-day old male infant admitted to 4NE on November 17, 2007 with a rash. Physician's order was for Acyclovir every 8 hours IV, and Vancomycin every 8 hours IV. Per hosptial protocol, Heparin Flush 10 units per milliliter is to be administered after the administration of IV medications.

14. Upon assessing Patients #1 and #2, who were still receiving IV medications started by the outgoing nurse, Valerie Bugnon, Respondent noticed that both patients had slight bleeding

[1] Cross-train consists of shadowing the primary nurse to become familiar with the routine functions and procedures in that unit.

from their IV sites and/or heel sticks. After the completion of the assessment, Respondent followed Nurse Shetty to the medication room and met Charge Nurse Kristen Voelker (Nurse Voelker). Nurse Voelker informed Respondent and Nurse Shetty that the IV medications on Patients #1 and #2 were completed and their IV pumps were turned off. Nurse Voelker then handed the two Heparin Flush syringes she prepared to Nurse Shetty, who in turn handed one of the syringes to Respondent to be used on Patient #2, while Nurse Shetty used the other syringe on Patient #1.

15. Between 1900 to 1945 hours, Respondent administered the Heparin Flush prepared by Nurse Voelker on Patient #2. Respondent did not document this intervention on any of Patient #2's medical records. At about 2115 hours, after having noticed slight oozing of blood from Patient #2's heel stick and his IV site, Nurse Shetty notified Nurse Voelker and the treating physician.

16. At 2240 hours, the Heparin drawer was discovered to contain Heparin vials 10,000 units per milliliter. Laboratory tests conducted that day revealed that Patients #1 and #2 were overdosed with Heparin. On November 19, 2007, two doses of a Heparin reversal antidote, Protamine Sulfate 25mg, were administered to both patients.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

17. Respondent is subject to discipline under Code section 2761, subdivision (a)(1) on the grounds of unprofessional conduct as defined under California Code of Regulations, title 16, section 1442, in that on or about November 18, 2007, while on duty as a cross-train nurse at 4NE at CSMC, Respondent was grossly negligent in the following respects:

a. Patient #2. Between 1900 to 1945 hours, Respondent administered a Heparin Flush which she herself did not prepare. Complainant refers to and incorporates all the allegations contained in paragraphs 12 – 16, as though set forth fully.

b. Patient #2. Between 1900 to 1945 hours, Respondent failed to verify the correct medication, patient, concentration, route, absence of discoloration and particulate matter of the Heparin Flush which was prepared by another nurse. Complainant refers to and

incorporates all the allegations contained in paragraphs 12 – 16, as though set forth fully.

SECOND CAUSE FOR DISCIPLINE

(Incompetence)

18. Respondent is subject to discipline under Code section 2761, subdivision (a)(1) on the grounds of unprofessional conduct as defined under California Code of Regulations, title 16, sections 1443 and 1443.5, in that on or about November 18, 2007, while on duty as a cross-train nurse at 4NE at CSMC, Respondent was incompetent in the following respects:

a. Patient #2. Respondent failed to document that at between 1900 to 1945 hours, she flushed Patient #2's IV line with Heparin Flush. Complainant refers to and incorporates all the allegations contained in paragraphs 12 – 16, as though set forth fully.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 638447, issued to Eva Bedford-Oppong;

2. Revoking or suspending Nurse Practitioner Advanced Certification Number 19215, issued to Eva Bedford-Oppong;

3. Ordering Eva Bedford-Oppong to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3;

4. Taking such other and further action as deemed necessary and proper.

DATED: 11/10/09

Louise R. Bailey

LOUISE R. BAILEY, M.ED., RN
Interim Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

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